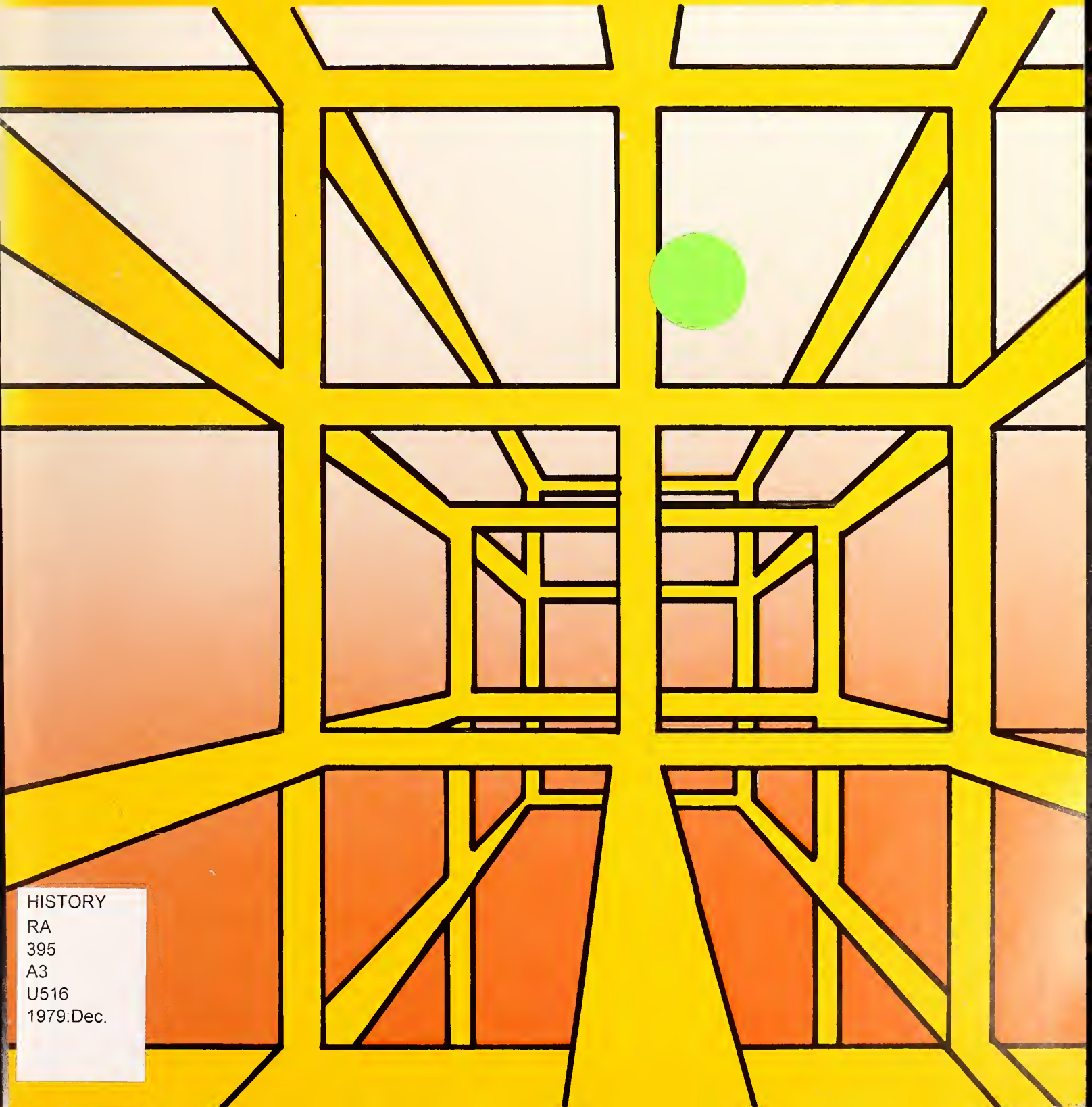
Health Care
Financing Administration

Forum

December 1979

SPECIAL ISSUE
A Guide to the Reorganized HCFA



Administrator's Report

In terms of both its budget and the number of people it serves, the Health Care Financing Administration is one of the largest enterprises, public or private, in the United States. In Fiscal Year 1980, HCFA will spend about $45 billion to provide for the health care needs of 50 million aged, poor, and disabled citizens in this country. Every day, about 800,000 Medicare and Medicaid beneficiaries see a physician; 300,000 receive care as hospital inpatients; and about 90,000 receive the services of nursing homes. In addition, thousands of other beneficiaries daily receive home health visits, drugs, health screenings, kidney dialysis, or a wide range of other services.

The agency's basic mission is to ensure the timely and appropriate delivery of these services through effective administration of Medicare, Medicaid, related quality assurance programs, and other programs. In addition, the agency must make certain that its beneficiaries are aware of the services for which they are eligible, that these services are accessible and that they are provided in the most effective manner. Finally, as the single largest purchaser of health care services in this country, HCFA must ensure that its policies and actions promote efficiency and quality within the total health care delivery system that serves all Americans.

The requirements for fulfilling this mission are complex and demanding. The Medicare and Medicaid programs are administered through a complicated set of relationships involving the private insurance industry, government institutions at the state and local level, and thousands of independent hospitals, physicians, and providers of services. Despite the magnitude of its responsibilities, HCFA is one of the smaller major agencies in the Federal Government, in terms of staff, with 4,600 employees. This staff must monitor 75,000 full-time employees of states and contractors as well as about 360,000 physicians, institutions and other Medicare and Medicaid providers.

In the past several years, the management challenge of administering Medicare and Medicaid has grown significantly. Changes in the economic and political climate in this country have created a new era of limits requiring better management than ever before of large Government-financed social programs.

Health care is now the third largest industry in the United States economy. Expenditures for all health care services increased from $69.2 billion in 1970 to a projected $178.8 billion in 1978. Medicare and Medicaid expenditures by both state and Federal Government increased from $11.8 billion to a projected $43.7 billion for the same period.

The slowing of the economy's growth rate makes it questionable whether Government spending can continue even at the current rate. Inflation, particularly in health care costs, threatens to push the cost of Government-supported health care programs beyond our ability to pay for even current levels of service. HCFA, as will all Government agencies, must ensure that every dollar is used effectively to meet critical program needs.

In addition to an era of financial constraints, we have entered a period of increasing skepticism by the American public over whether large Government social programs can be managed effectively without waste and abuse. The demand for better control in spending public funds in Medicare, Medicaid, and other programs grows daily.

These trends require that we increase the efficiency of our programs; that we eliminate whatever fraud, abuse, and waste that may exist; and vide care only in the most appropriate setting. We must improve our management practices both to get maximum services for the money spent and to restore public confidence. that we ensure funds are used to pro- Without that confidence, the new era of limits will increasingly constrain the resources that are made available to meet the health care needs of our most vulnerable citizens.

In the past nine months, HCFA has undertaken a number of initiatives to meet these management challenges. On June 20, the agency implemented a major reorganization of its central office components, integrating for the first time national administration of the Medicare and Medicaid programs. Also in June, we consolidated the staff for the first time in a single geographical area.

HCFA has also initiated a number of internal management efforts to improve management control, to unify the collection and processing of data and to evaluate managerial performance. Finally, we have established an agenda of key priorities for the next year. These include:

- Better performance standards for contractors and states and improved quality and financial control over program expenditures,
- Reduction of fraud and abuse,
- Simplification of Medicare and Medicaid program administration,
- Reform and control of Medicare and Medicaid reimbursement, and
- Improved understanding by our beneficiaries of their rights and responsibilities as health care consumers.

The following pages of this issue of the *Forum* describe in more detail HCFA's new organizational structure and some of the other changes we have made. Although a relatively young agency, HCFA is moving ahead to address the management challenges of health care in the 1980s.

Forum

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Martin Judge, Editor

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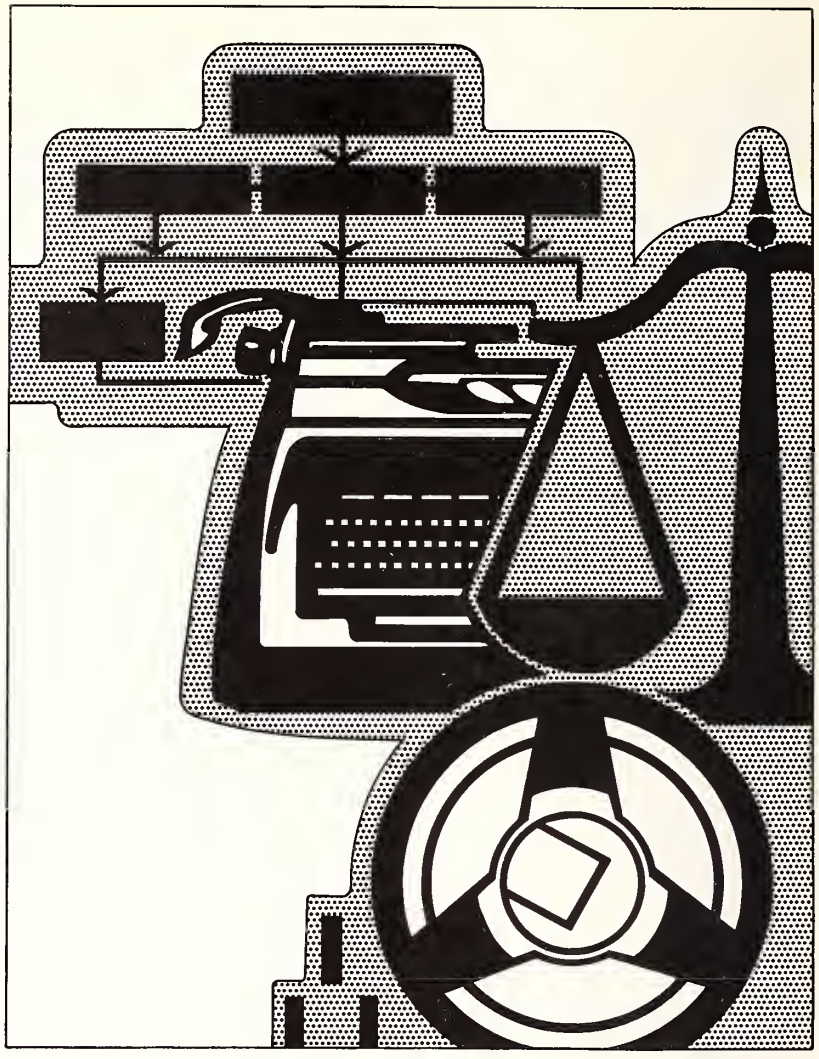
HCFA Staff Offices



The functional organization of the Health Care Financing Administration that resulted from formally reorganizing the agency on June 20, 1979 contributes not only to the more efficient performance of HCFA's day to day tasks, it also provides the organizational groupings and channels of communication that promote consistent policies and a decision-making process based on complete, accurate information, and the involvement of all appropriate units of the organization.

Contact points are sharpened, making the agency easier to deal with for HCFA's constituents, while, internally, staff benefits from improved organizational vantage points.

The staff offices of the agency contain several examples of this improvement. In addition to serving the Administrator, they also support activities of his deputy, Earl M. Collier, the second-ranking officer of the agency. An attorney with a background in health regulation and a former official of the New York State Office of Health Systems Management, Collier is also currently acting director of the Office of Special Programs, one of the units of the immediate Office of the Administrator.

Administrator's immediate office

The Office of Special Programs focuses primarily on two programs that cut across a number of HCFA orga-

Deputy Administrator Earl M. Collier, Jr., is the agency's second ranking executive.

nizational units. A subunit, the Office of Child Health, is responsible for developing HEW's strategy for health care for poor children and works jointly with the Public Health Service to improve the coordination of the department's child health resources. Another subunit, the Office of End-Stage Renal Disease, administers a program that treats persons with terminal kidney disease. The kidney treatment program was established in 1972 as the first national catastrophic health care program.

Another unit of the administrator's immediate staff insures, through liaison with the health care community that the views of physicians, hospitals, administrator's and national professional organizations are represented in the decision-making process. This is the Office of Professional and Scientific Affairs, directed by Dr. Roger O. Egeberg, a former practicing physician, who has served as HEW's Assistant Secretary for Health and as dean of the University of Southern California's School of Medicine.

Helping to mesh the programmatic gears of HCFA with those of the states, local governments, and other Federal agencies is the responsibility of the Office of Intergovernmental Affairs. Directing this office is Richard W. Heim, former executive director of New Mexico's Health and Social Services Department, who most recently served HCFA as director of its Medicaid Program. In addition to reviewing all HCFA policies, legislative proposals, and penalties affecting Federal, state, and local agencies, the office acts as an ombudsman to explain policy and procedures and to help solve problems.

The Office of Health Regulation assesses the costs and effectiveness of selected health care regulations that affect hospitals, nursing homes and other institutions. An important part of this activity is determining if the incentives of these regulations tend to lower or raise the cost or quality of care. The office, which is funded and staffed jointly by the Public Health Service as a two-year task force, is directed by John Reiss.

Improving services to Medicare and Medicaid beneficiaries is the single goal of the Office of Beneficiary Services. While all elements of the agency are of course concerned with improving services, this office was established to act as a catalyst for improving all aspects of services. The office is the agency's primary contact point with groups representing beneficiaries. The office is directed by Barney Sellers, former deputy director of the American Health Planning Association and former director of HCFA's Child Health Services.

Kevin J. Sexton (Center), director of the Office of Executive Operations, meets with John Reiss (left), director of the Office of Health Regulation, and George James, director of the Office of Equal Opportunity.

The Office of Equal Opportunity monitors the agency's employment practices and develops affirmative action programs for hiring and promotion to conform with the Federal employment opportunity regulations. During the last fiscal year, the office helped increase the percentage of women in senior level jobs from 16.3 percent to 18 percent. At the same time, the percentage of minority employees as a whole at this level increased from 9.3 to 9.8. The office, working with HEW's Office of Civil Rights, also promotes voluntary civil rights compliance by health care providers who receive Medicare and Medicaid funds, including state Medicaid agencies, hospitals, skilled nursing homes, and intermediate care facilities. The office is directed by George James.

In addition to the staff offices in the immediate office of the Administrator, there are four major staff offices of the agency that cover broad areas of legislation, policy, and budget development, HCFA research and statistical activities, and public affairs.

Office of Executive Operations

The orderly flow of information through the office of any chief executive in a large organization is critical to the success of that organization. In HCFA, that role is held by the Office of Executive Operations, which manages that information flow and shepherds the mechanics of the agency's decision-making process.

Kevin Sexton, director of the Office of Executive Operations, is a former special assistant to the HCFA Administrator.

The office integrates previously separate responsibilities for resolving issues and developing regulations, tracking correspondence and assignments, coordinating field operations, and issuing formal instructions to the agency's staff, contractors, states, and health care providers.

"The goal of the office is to ensure the Administrator is provided with the information and analysis necessary to manage HCFA and that the agency operates in a manner consistent with its policies and meets its re-

Directors of the agency's four major staff offices are (from left) James Kaple, acting director of the Office of Research, Demonstrations and Statistics; Patricia Schoeni, director of the Office of Public Affairs; Jeffrey Merrill, director of the Office of Legislation and Policy; and Howard Phanstiel, director of the Office of Management and Budget.

sponsibilities to outside constituencies," Sexton told the *Forum*. The office consists of the agency's Executive Secretariat, the Office of Regulation Management, the Office of Field Operations, and the Office of Issuances.

The Executive Secretariat ensures that issues presented to the Administrator are fully developed and reflect all relevant viewpoints. It also monitors the agency's progress in responding to assignments from the Administrator and the Secretary, as well as to outside inquiries.

The Office of Regulation Management oversees the agency's system of developing regulations. It manages the development of an agenda for issuing regulations and ensures that regulations are consistent with the overall agency goals and objectives. It ensures that all issues associated with regulation proposals are considered in detail, guides proposals through the regulation process, and reports to the Administrator on HCFA's progress in meeting its production schedules.

The Office of Issuances coordinates the agency's internal policies for distribution to regional offices, states, fiscal agents, and providers, making sure the materials are prepared promptly and that they are consistent with agency policies and instructions.

The Office of Field Operations serves as an extension of the Administrator in relaying administrative and program decisions to HCFA's 10 regional offices. It ensures that information and viewpoints from the regional offices are available to the Administrator. It also provides the Administrator with information on regional office performance.

The underlying assumption in combining these functions was the benefit to HCFA obtainable from a close working relationship among the staffs within the Office of Executive Operations. For example, the quality of a specific regulation is improved by early involvement by both the bureaus and the regional offices. The close organizational relationship between the Office of Regulations Management, the Executive Secretariat, and Office of Field Operations facilitates this involvement.

This consolidation can also help meet the HCFA goal of "consistency in our dealings with those outside the agency for whom an understanding of our policies are critical to their operation," said the HCFA Administrator.

Research, Demonstrations, Statistics

A key office within HCFA, the Office of Research, Demonstrations, and Statistics, provides overall policy guidance to the agency, the department, and Congress on new initiatives in the Medicare and Medicaid programs and the overall health care community.

Recommendations are developed through two major activities: (1) the funding of research, demonstrations, and evaluation projects directed towards new methods of organizing, financing, and delivering health services; and (2) the analysis of Medicare and Medicaid program and national health care statistics.

Major research and demonstration initiatives include:

- Containing hospital and overall health care costs,
- Developing alternative and more cost-efficient methods of reimbursing providers and physicians under the Federal programs,
- Devising new and better ways of financing and delivering long-term-care services,
- Developing new and improved data and information systems,
- Restructuring the organization of health care delivery,
- Determining the utilization and costs of health care for Federal beneficiaries,
- Determining the quality and impact of the Federal programs on beneficiaries.

During Fiscal Year 1979, the office approved $32.5 million in research and demonstration grants and contracts. These projects were directed toward resolving a variety of issues in the financing and delivery of health care services under federal programs.

In addition to supporting demonstration and research projects, the office supports external evaluation studies that assess the utilization, cost, and administrative feasibility of the experimental approaches. The results of the research, evaluation, and demonstration projects are used to provide recommendations for improvements in the Medicare and Medicaid programs. Project results have been incorporated in the following ways:

- Development of proposals for new legislation (Federal and state),
- Revision of Medicare and/or Medicaid regulations and operating procedures,
- Changes in state Medicaid plans,
- Development of technology and data to support new policy directions in health care financing.

The data analyses and studies are disseminated nationwide through a series of publications including the quarterly *Health Care Financing Re-*

view, a quarterly summary of statistics entitled *Health Care Financing Trends*, and a series of other publications containing descriptive statistics on Medicare and Medicaid programs.

The Office of Research, Demonstrations, and Statistics serves as the primary Federal statistical office for the compilation of economic data on the health care sector. In this capacity, the office functions as the corollary to the Bureau of Labor Statistics for national health by compiling national statistics on health care and monitoring national health care costs and expenditures for specific goods and services.

Discussing agency strategy are (from left) Richard Heim, director of the Office of Intergovernmental Affairs; Barney Sellers, director of the Office of Beneficiary Services; and Dr. Roger Egeberg, director of the Office of Professional and Scientific Affairs.

Office of Public Affairs

Sometime this winter a television viewer will sit back while television and film star Cliff Robertson delivers a brief message on the advisability of getting a second opinion when your physician suggests non-emergency surgery. The nationwide radio/television campaign is one of several activities currently being developed by the Office of Public Affairs to inform the public of HCFA's programs and activities and to encourage a two-way understanding between the agency and the people it serves.

A staff of some 15 writers, editors, and information specialists—many of them veterans of such organizations as The Associated Press, the American Broadcasting Company, major newspapers, and several public relations firms—conduct programs to inform the public, assist the news media, and help other HCFA programs publish information of interest to those involved in health care financing, health planning, and health care.

In addition to the second opinion campaign, through which some six million publications have been distributed and a toll-free telephone line provides information on how to obtain a second opinion, the Office of Public Affairs has recently prepared and distributed more than three million copies of "Guide to Health Insurance for People with Medicare," containing information about shopping for private health insurance and explaining what Medicare pays and doesn't pay.

The publication was developed with the National Association of Insurance Commissioners. The Office of Public Affairs frequently cooperates with non-Federal organizations, both to provide them with information and to obtain their cooperation in meeting mutual objectives. The office arranges for HCFA executives to fill numerous speaking requests annually from national consumer and profcssional organizations, to help explain agency policy, and to learn the concerns of the organizations.

Assistance is also provided in the agency's process of developing regulations, so that comments from national organizations and the general public can be considered before the regulations become final.

Forum, the semi-monthly magazine of the Health Care Financing Administration, is another vehicle through which the Office of Public Affairs provides information to persons and organizations concerned with health care financing, and the readership is invited to submit articles for publication.

Patricia Q. Schoeni, director of the Office of Public Affairs, has spent more than 15 years in health-related Federal information programs. She is a former magazine writer.

Office of Legislation and Policy

The Office of Legislation and Policy, directed by Jeffrey Merrill, is concerned with the formulation of agency policy and the development of HCFA's legislative program. The primary responsibility of the office is to support the Office of the Administrator and other components of HCFA in the legislative and policy areas.

The office identifies and analyzes issues influencing HCFA and HEW health care programs and evaluates how the objectives of these programs can best be supported legislatively. The office is also HCFA's liaison with executive offices and congressional committees concerned with health care delivery programs.

The recent HCFA reorganization consolidated the legislative planning, congressional relations, and policy analysis activities that were previously divided among separate components. The consolidation is expected to ensure greater consistency and coordination of policy and to facilitate development of the agency's legislative program.

Within the Office of Legislation and Policy, the Office of Legislation and Congressional Affairs provides leadership and direction in the development of HCFA's legislative programs. The Office of Policy Analysis performs policy studies for the Administrator and integrates the results into the legislative planning process.

The Office of Legislation and Congressional Affairs develops or reviews legislative initiatives affecting health care financing programs, including Medicare, Medicaid, and the Professional Standards Review Organization Program. It analyzes current and pending legislation and responds to congressional requests for information on HCFA programs.

In addition to its analyses, the staff

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Bureau of Program Policy

by Dominic C. Jollie

The mission of the Bureau of Program Policy, according to its acting director, Robert D. O'Connor, is to enhance the access by all Americans to quality health care at a reasonable cost. "The reorganization of HCFA will enable us to be more responsive to the health needs of the American people and to make our knowledge more readily available to Congress and to the Administration, as our Government develops both cost containment strategies and new programs aimed at new segments of our population."

The bureau is composed of elements from the former Medicare and Medicaid Bureaus, plus the Office of Reimbursement Practices. However, in O'Connor's view, the reorganization goes beyond a mere restructuring of HCFA. "It recognizes that the problems faced by the American people in the delivery and financing of health care cannot be effectively addressed from the standpoint of any particular program." Thus, the reorganization transforms HCFA from a group of agencies, each having a specific mission, into a single entity that goes beyond just Medicare and Medicaid.

"With this viewpoint in mind, we have fashioned a functionally oriented bureau, with three major policy components—eligibility, coverage, and reimbursement. We have also centralized the drafting of regulations, in an effort to promote greater efficiency and more consistent quality in the articulation of program policy.

Eligibility policy

The Office of Eligibility Policy defines the conditions under which persons are eligible to receive Medicare and Medicaid benefits. Within this office are the Division of Medicare Eligibility Policy, the Division of Medicaid Eligibility Policy, the Division of Technical Policy and Litigation, and the Hearings Staff. This is the only area in the Bureau where there is an explicit organizational differentiation between the Medicare and Medicaid programs.

The Hearings Staff gives health care providers the opportunity to rebut administrative decisions related to fraud and abuse, the amount of reimbursement, and other program matters with which they are concerned.

Spelling out the statutory conditions under which persons are eligible for Medicare benefits is the responsibility of the Division of Medicare Eligibility. This division also addresses various aspects of a beneficiary's deductibles and coinsurance, overpayments and underpayments to beneficiaries, claims for payment and disputed claims, and technical statutory exclusions from coverage.

Similarly, the Division of Medicaid Eligibility seeks to clarify the conditions under which persons are eligible to have the cost of their health care reimbursed under Medicaid. The principal areas of concern here are financial eligibility requirements, beneficiary rights, eligibility of institutionalized persons, residence requirements, eligibility of the "medically needy," citizenship requirements, and related issues.

In cooperation with HCFA's Office of General Counsel, the Division of Technical Policy and Litigation develops and coordinates HCFA's position on civil suits and bankruptcy proceedings, formulates recommendations for appeals and compromise settlements, and represents the agency when health care providers and others appeal its rulings.

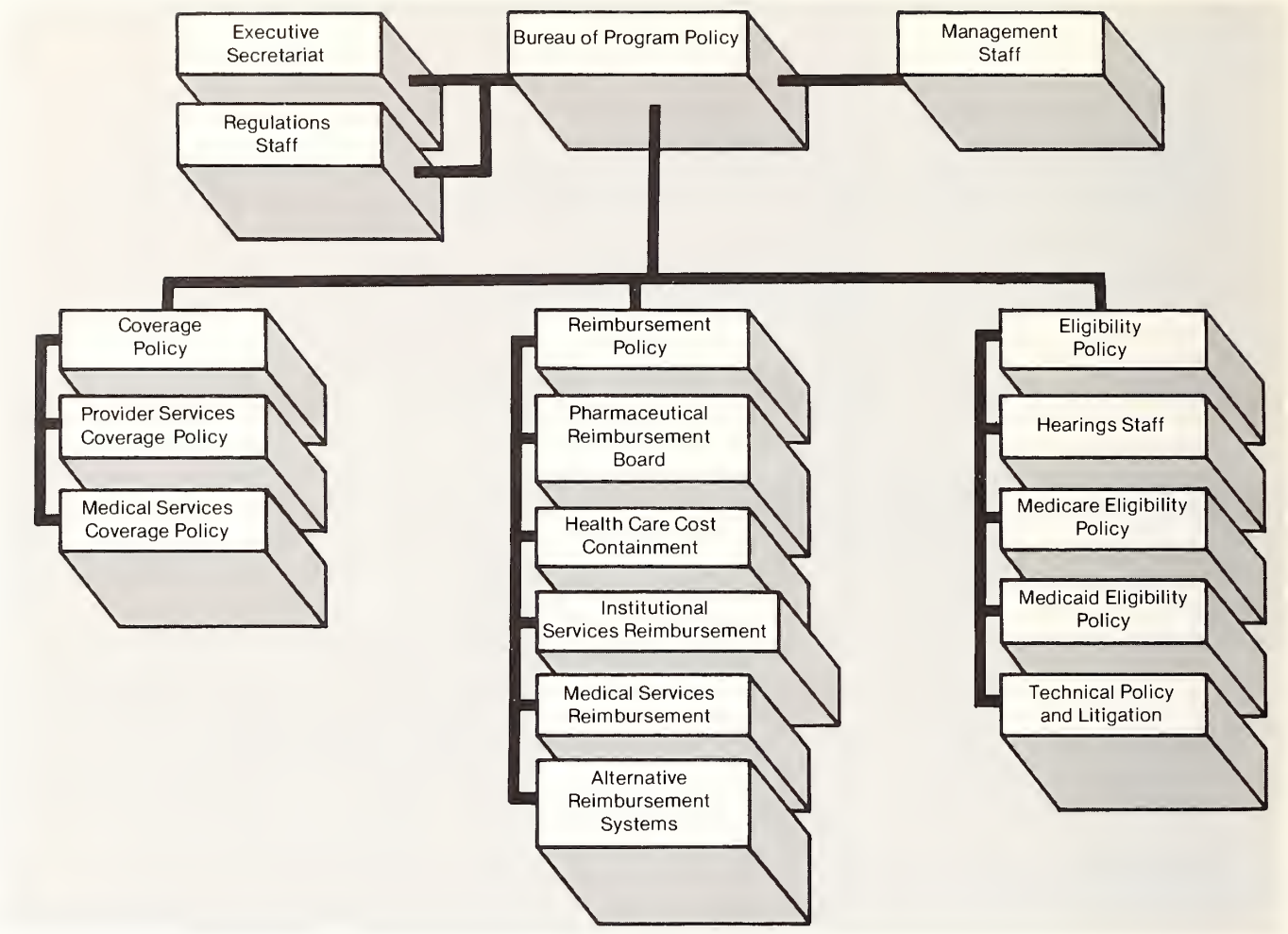
Coverage policy

Basic definitions of coverage are contained in the Medicare and Medicaid laws, and additional explanations of the intent of Congress are contained in congressional committee reports. Nevertheless, it is necessary to define the covered services, and the circumstances under which they are covered, in greater detail. This is the responsibility of the Office of Coverage Policy.

This office interprets the law for Medicare contractors and Medicaid fiscal agents, so that they can make correct payments of claims and provide clear explanations to beneficiaries. It is also responsible for developing policy on when various forms of institutional care—hospitals, skilled nursing facilities, and intermediate care facilities—can be paid for, the kinds of services covered in such areas as occupational therapy and speech therapy, and the types of medical practitioners whose services can be reimbursed.

The services of physicians and other medical practitioners are subject to many provisions of the Medicare and Medicaid laws, including specifications regarding the extent to which their services are covered. For example, all services provided in a physician's office are not automatically covered under Medicare. The Office of Coverage Policy must fully define statutory terms and inform Medicare carriers and others about the types of services for which payment will be made.

Many coverage questions arise about particular items and services,



such as medical procedures, supplies, or devices. For example, Medicare covers "durable medical equipment," which includes such items as wheelchairs, iron lungs, and oxygen equipment. Each year the program's contractors are faced with claims for many new types of equipment, procedures and services which may or may not fit existing definitions. As a result, the office must decide if the new items fit the legal definition of covered services.

Medicare and Medicaid laws contain various provisions governing the coverage of such routine items as eyeglasses and prescription drugs. The coverage staff clarifies detailed policies so that intermediaries and fiscal agents can determine which services and items can be paid for and which claims must be denied.

Reimbursement policy

How much the Government pays, how much providers receive for services, and how much the beneficiaries must pay out of their own pockets are questions dealt with by the Office of Reimbursement Policy.

Within the office, the Division of Institutional Services Reimbursement has the responsibility for formulating policy for the reimbursement of hospitals, skilled nursing facilities, and home health agencies. The division is also responsible for developing guidelines for use in establishing the reasonableness of institutional provider costs, policies for the accounting and auditing of provider costs, and the cost reimbursement aspects of state medical assistance plans.

Another component of the office is the Pharmaceutical Reimbursement Board, which sets limits on the amount HCFA will reimburse for drugs that are available from more than one source. These limits are established after the staff studies the drug market and determines the lowest price at which drugs are widely available.

The Division of Alternative Reimbursement Systems develops policies for reimbursing alternative methods of health care delivery, such as Health Maintenance Organizations, Rural Health Clinics, and prepaid health plans. The division also is responsible for reimbursement policies for long-term-care facilities and inpatient hospital services for states not using the Medicare principle of reimbursement.

The Division of Health Care Cost Containment addresses one of HCFA's major health care goals—containing rising costs in hospitals, nursing homes, and home health agencies. Cost limits for routine hospital care have been in effect for five years. Each year the methodology for setting these limits is refined, based on newer data and more sophisticated analysis. Recently, cost limits were published for home health agencies and for skilled nursing facilities.

The Division of Medical Services Reimbursement deals with payments for physician and dental services, prosthetic devices and medical equipment used at home, and for items such as laboratory tests, prescription drugs, eyeglasses, ambulance trans-

Robert O'Connor, Bureau of Program Policy, studies agency goals.

portation—and even for such high-cost items as CT scans.

Regulations and development

Prior to HCFA's reorganization, the responsibility for developing regulations was dispersed throughout the agency. Now, most HCFA regulations will be written by a single staff of specialists in the Bureau of Program Policy, based on analysis and specifications proposed by other units in the bureau or by other components in HCFA.

This functional division of responsibility allows the policy analysts to concentrate on reviewing current problems, evaluating alternative solutions, and developing supporting data and rationales. The regulations staff is skilled in the clear and comprehensive presentation of policy solutions and remains up-to-date on the drafting conventions and the format and style favored by HEW and the Executive Branch. Their goal is to make sure that regulations are understood by those affected by them and to make sure the agency has fully explained our policy.

Inquiries staff

Another important task not to be overlooked is the bureau's extensive operation responding to thousands of inquiries. Because so many of the letters coming to HCFA from beneficiaries, providers, members of Congress and others ask about HCFA policies and how they affect specific situations, the bureau answers about half of all the inquiries received by HCFA. With this volume, providing clear, understandable, and accurate responses in a timely manner becomes a major focus of our activity.

The bureau's goals

In order to promote its mission of enhancing access to quality care at a reasonable cost, the bureau has established the following specific policy goals:

- Refine institutional reimbursement policies to eliminate costs that are not necessary for the efficient delivery of needed health care.
- Implement more rigorous cost limit methodologies to eliminate excessive costs while allowing flexibility for exceptional circumstances.
- Clarify charge reimbursement policies for physicians and develop cost saving innovations for reimbursing medical services and supplies.
- Develop innovative reimbursement policies for special types of providers, including prospective rate systems, with incentives for more efficient delivery of health care.
- Provide coverage for the broadest possible range of safe and effective items and services, subject to the "reasonable and necessary" test.
- Clarify and simplify eligibility policies, in order to maximize beneficiary access to health care.
- Maximize state and Federal resources by preventing and deterring fraud, abuse, and waste in the administration of the program.
- Clarify ambiguities in existing policies that have given rise to inaccurate decisions, administrative disputes and litigation.

All of the bureau's components work together to achieve these goals and all of their activities are evaluated against these goals. This is an ambitious undertaking. However, possibly for the first time, there is a unifying thread running through HCFA programs and a set of clearly stated objectives against which our efforts can be measured.

Dominic C. Jollie is acting chief of the Bureau of Program Policy's Inquiries Staff.

Bureau of Support Services

by Kathy Adams

One of the major changes to take place in HCFA's reorganization was the establishment of the Bureau of Support Services. The largest and most diversified operating component of the agency, this bureau consolidates centrally performed claims processing and other computer operations which were previously carried out for Medicare by the Social Security. Administration and various HCFA components.

The bureau also provides centralized automated data processing and telecommunications, computerizes and stores health care program records, and reimburses physicians, institutions, and other health care providers that choose to receive Medicare payments directly from the Government. It is this bureau that issues Medicare cards to the programs' 31.5 million beneficiaries and maintains their accounts.

By integrating the various data processing systems into a single health care information system, HCFA can better serve the health care community with speedier accessibility to a higher quality of information.

According to Ralph Howard, bureau director, "One of the biggest challenges for the Bureau of Support Services will be to spearhead the structuring and integration of health care information systems and to develop a health care data base." In the event national health care legislation is enacted, this endeavor could serve as the cornerstone for the work which will be necessary.

To understand bureau activities in greater detail, it is necessary to examine the functions of its offices and staffs—the Office of Direct Reimbursement, Office of Health Program Systems, Office of Administrative Systems, Office of Computer Operations, and Systems Policy and Planning Staff. There is also a Management Staff which provides administrative management support for the bureau.

Direct reimbursement

During Fiscal Year 1979, health care providers submitted more than 2.4 million claims to HCFA for reimbursement. This resulted in payments of over $500 million.

The Office of Direct Reimbursement serves as the fiscal intermediary for health care professionals and institutions that elect to receive Medicare payment directly from the Federal Government. It reimburses over 1,300 hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, and comprehensive health centers. It also processes claims from Medicare beneficiaries living outside the continental United States and performs some carrier functions. In fact, the office serves health care providers (including Federal hospitals) in all states, Puerto Rico, and the District of Columbia.

Because of this large claims volume and mix of providers, the Office of Direct Reimbursement employs a highly automated bill processing system. Efforts are underway to improve claims processing efficiency through various methods of "paperless billing," including submission of bills on magnetic tape or via telecommunications. Most of the work in this area has been performed in conjunction with state health systems and with large chain organizations interested in paperless processing. Some advantages of paperless billing systems include:

- Greater productivity,
- Increased control,
- Reduced mailing costs,
- Faster payment to providers, and
- Reduced administrative costs.

In some ways, the Office of Direct Reimbursement is a laboratory for new methods of claims processing. Advancements in automated claims processing permit the HCFA system to serve as a model for interested intermediaries.

The office also is involved in experiments with innovative health care delivery programs. Determining the cost and effectiveness of these experimental alternatives is important and may prove to be significant in structuring a national health insurance program.

Health program systems

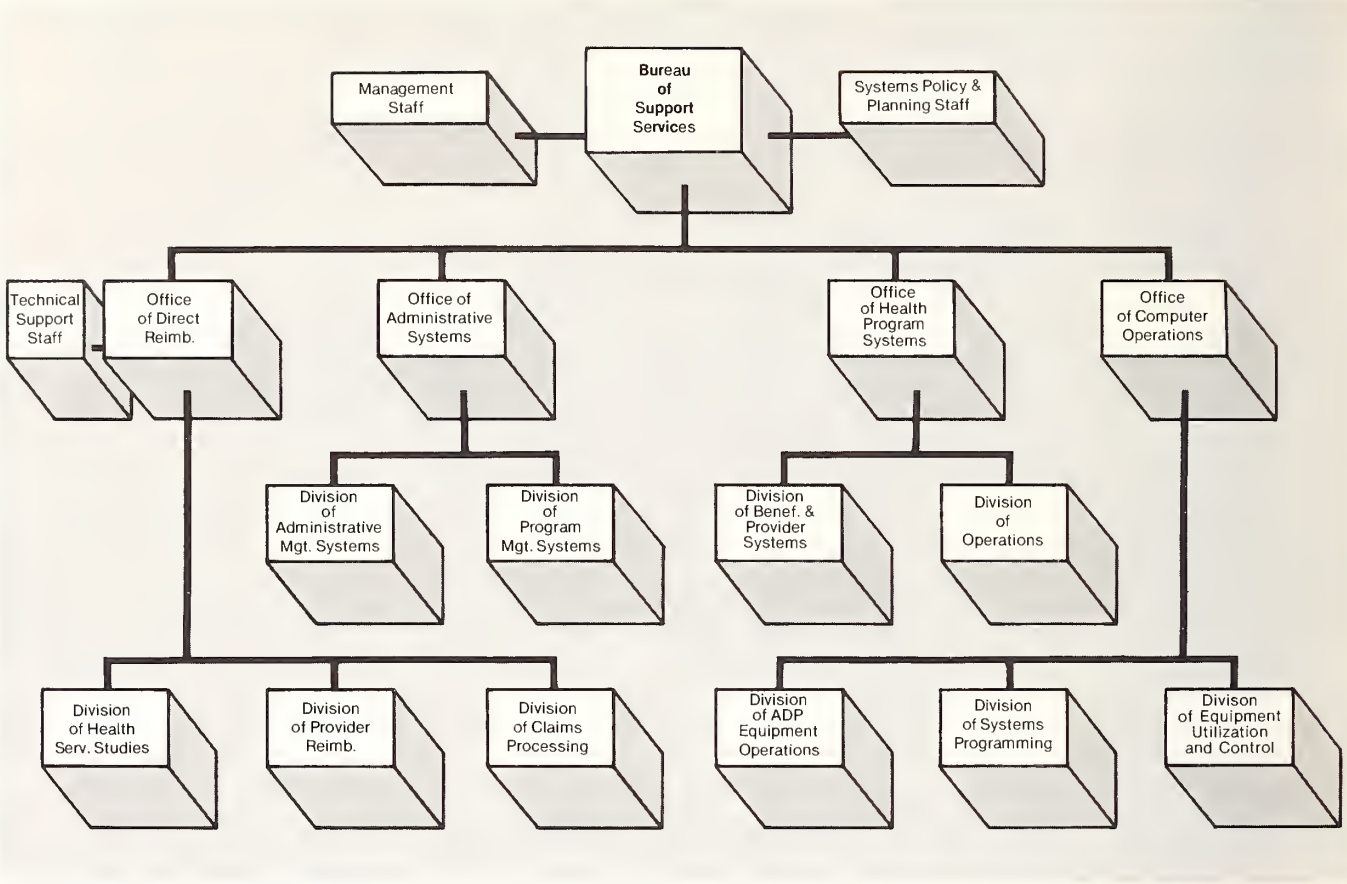
The Office of Health Program Systems operates a data processing system that facilitates paying Medicare bills and, as a by-product, collects data to form a massive data base. Currently, the system focuses on:

- Updating the status of Medicare beneficiaries so that their eligibility for services is known at all times;
- Collecting supplementary medical insurance premiums;
- Updating records on providers certified to participate in the Medicare and Medicaid programs;
- Maintaining member rolls of HMO's and group practice pre-payment plans; and
- Maintaining a running account of payments to providers.

The office maintains computerized records on 31,500,000 active beneficiaries and 13,500,000 inactive beneficiaries. Each record contains the history of benefits received and documentation of eligibility. This system is designed so that data can be continually exchanged between the central data bank in Baltimore and the nationwide network of Medicare contractors, local Social Security offices, state agencies, and the Railroad Retirement Board.

Each year, the system processes more than 100 million eligibility queries and 36 million entitlement transactions. It also receives, edits, and stores information contained in 168 million bills and payment records annually.

The system is used to issue Medicare cards to beneficiaries, to provide



them with an up-to-date account of the benefits they have received, and to transmit records of payments to hospitals, skilled nursing facilities, home health agencies, and other facilities.

Under HCFA's reorganization, all functions and staff that support this system have a single manager. The consolidation is expected to yield quicker resolution of problems, a greater degree of accuracy, and increased speed in data exchange with intermediaries, the health care community, and beneficiaries.

A new unit has been established within the office to develop and implement mechanisms to ensure quality control and timeliness of operations. While data has been carefully edited before being introduced into the system in the past, these efforts are being intensified through a more consolidated approach to validation activities.

The Office of Health Program Systems provides systems support to other HCFA and HEW components that develop, conduct, or evaluate health care research and demonstration projects. Such research often involves studying the effects of increasing benefits or of removing barriers to health care. For example, to accommodate a recent demonstration project, the master file of providers was modified to accept Medicare bills from skilled nursing facilities when admissions were not preceded by the three-day hospital stay now required.

An immediate objective of the office is to eliminate, where feasible, all manual processes to reduce manpower, paperwork, and human error in day-to-day processing. Other major projects underway include increased use of electronic transmission of payment data from Medicare carriers to the central system, improved speed in issuing Medicare cards, and increased security measures to ensure the confidentiality of all data.

Administrative systems

Before HCFA's reorganization, the responsibility for health care and administrative information systems was divided among various agency offices. Consolidation of this responsibility into a single Office of Administrative Systems is expected to improve the quality and timeliness of health care data; thus, the information needs of HCFA, the health care community, the Congress, and the public will be better served.

The office designs and maintains health care and administrative information systems, advises HCFA components on automated office equipment, and handles all correspondence relating to records maintained on services to beneficiaries.

Consolidation presents the opportunity to use information systems as effective management tools in administering and evaluating HCFA's health care programs. One major project this office will undertake, in conjunction with the Bureau of Quality Control, is the design and implementation of a series of monitoring systems to detect potential cases of fraud and abuse.

Several improvements in data collection and distribution techniques are underway. One example is the Medical Information System for terminal kidney disease. This system compiles medical information on kidney patients which is useful to networks of facilities that treat kidney disease, to physicians, and to HCFA components. Aimed at providing information on basic patterns of care, this system will serve as a basis for other medical information systems which

would be developed, should legislation be enacted to expand catastrophic health care coverage.

In addition to medical information, the system routinely provides a broad range of information to HCFA policy makers and operating personnel. One area in which information is of great assistance to policy makers is provider costs. Provider cost reports currently are being sampled to determine the cost limits that should be applied under HEW cost containment initiatives. Information systems will also be developed to make the agency more responsive to the public by simplifying regulation processes and correspondence control systems.

The use of automated office equipment, such as word processors, to maximize efficiency, improve quality, and speed communications with intermediaries, providers, and the public is being assessed. Preliminary findings are that numerous areas in the agency could benefit from such equipment, including correspondence reply units and those involved in the issuance of policy, regulations, and manuals.

Computer operations

The Office of Computer Operations is responsible for managing the agency's computer operations. Currently HCFA has limited equipment of its own and depends on other HEW computer centers for most of its major data processing requirements. The immediate goals of this office are to determine HCFA's total computer needs and to establish its own computer center.

A primary advantage of a HCFA computer center would be that the agency could set its own data processing priorities, thus ensuring prompt processing of critical data. A HCFA computer center also would provide greater latitude to experiment with quality control methods (for increased accuracy of automated systems) and the opportunity to expand the use of automated processing and integrate all automated processing within the health care financing program. Systems can be designed to enable HCFA to respond more quickly and more completely to legislative initiatives and be flexible enough to adapt to changing program needs.

Policy and planning

In accordance with Federal regulations, the Systems Policy and Planning Staff develops HCFA policies and standards for all aspects of internal data processing and telecommunications activities and ensures that HCFA systems are professionally developed and adequately documented.

This staff is developing long-range strategic plans and short-range tactical plans for the agency's automated data and information systems. All bureau and office needs throughout HCFA are being combined into a comprehensive plan that defines the agency's overall systems requirements through the mid-1980s. Plans are being made also to develop a systems capability which will give regional offices immediate access to a range of information to more effectively assess performance of states, intermediaries, and carriers in the administration of the Medicare and Medicaid programs.

Kathy Adams is a management analyst in the bureau's Office of Administrative Systems.

Ralph Howard, director of the Bureau of Support Services, checks computer.


MEDICARE REIMBURSEMENT
MEDICAID REIMBURSEMENT

Bureau of Program Operations

by Martin Dyer

The Bureau of Program Operations is the HCFA component that provides national policy, direction, and oversight to the operations of the Medicare and Medicaid programs. These operations are handled for Medicaid on a shared responsibility basis with state agencies and for Medicare for most functions under contractual arrangements with private agencies. For that reason, the scope of the bureau's activities extends to the 10 HCFA regional offices, 119 Medicare contractors and 53 state agencies, employing a total of about 65,000 persons.

The bureau's activities also directly affect providers of services and the 45 million beneficiaries of these programs as it determines the forms and processes to be used for claiming reimbursement for health services. With the integration of Medicare and Medicaid operations under a single bureau, priority will be given to eliminating duplicate demands on providers and to improving services for beneficiaries, particularly the four million covered by both programs.

From a national perspective, the Bureau of Program Operations:

- Manages the contractual framework for Medicare operations and the administration of state plans for Medicaid,
- Ensures that contractors and state agencies have effective systems for doing their work,
- Establishes performance standards for the states and contractors,
- Assures that performance standards are met, and
- Assists in correcting problems.

The Bureau of Program Operations is composed of four offices—the Office of Program Administration, the Office of Standards and Performance Evaluation, the Office of Methods and Systems, and the Medicaid/Medicare Management Institute.

Program administration

Medicare intermediaries and carriers are private or public organizations which, on behalf of the Government, provide direct service to health care providers and program beneficiaries. The Office of Program Administration develops and negotiates contracts with these organizations for their services and approves or disapproves program operation plans submitted by the state Medicaid agencies. Since public funds are used by both contractors and state agencies to provide services to beneficiaries, vigilant budget and funding control is necessary. That control is exercised by the Office of Program Administration.

Although a national program, Medicaid is administered by the individual states. HCFA-approved state Medicaid programs are funded in part by the Federal Government and in part by the state and local governments. Thus, there is less direct control exercised by HCFA over Medicaid program operation than over Medicare which is 100 percent federally funded.

Also part of the bureau is a special staff, the Group Health Plans Operations Staff. It is concerned with Health Maintenance Organizations and Group Practice Prepayment Plans.

The Office of Program Administration compiles information about Medicaid state plans and contracts between state agencies and fiscal agents, and monitors reports on compliance with those plans. To a large extent, correction of program deficiencies depends upon the good will and the interest of the state in providing Medicaid benefits economically and efficiently. Compliance issues are generally resolved between the states and the regional offices; the Office of Program Administration assists in those negotiations and further actions.

In carrying out its function, the Office of Program Administration analyzes the program operations of both the Medicare and Medicaid programs and assesses the real and potential impact of new regulations, policies, and procedures. It also determines the potential benefit of new contract or incentive approaches for more effective performance by contractors.

Evaluation

How fast should claims be processed, what error rate is acceptable, and what cost is reasonable for processing a claim? How well do contractors and state agencies meet established standards, and what should be done when they fail to do so? These and similar questions are addressed by the bureau's Office of Standards and Performance Evaluation. This office sets performance standards for contractors and state agencies and evaluates their work to assure standards are met.

To evaluate those who serve Medicare and Medicaid beneficiaries, regional offices conduct inspections, make regional assessments, and decide on and monitor corrective actions. Through regional reports and recommendations, the Office of Standards and Performance Evaluation has the data necessary to carry out its activities.

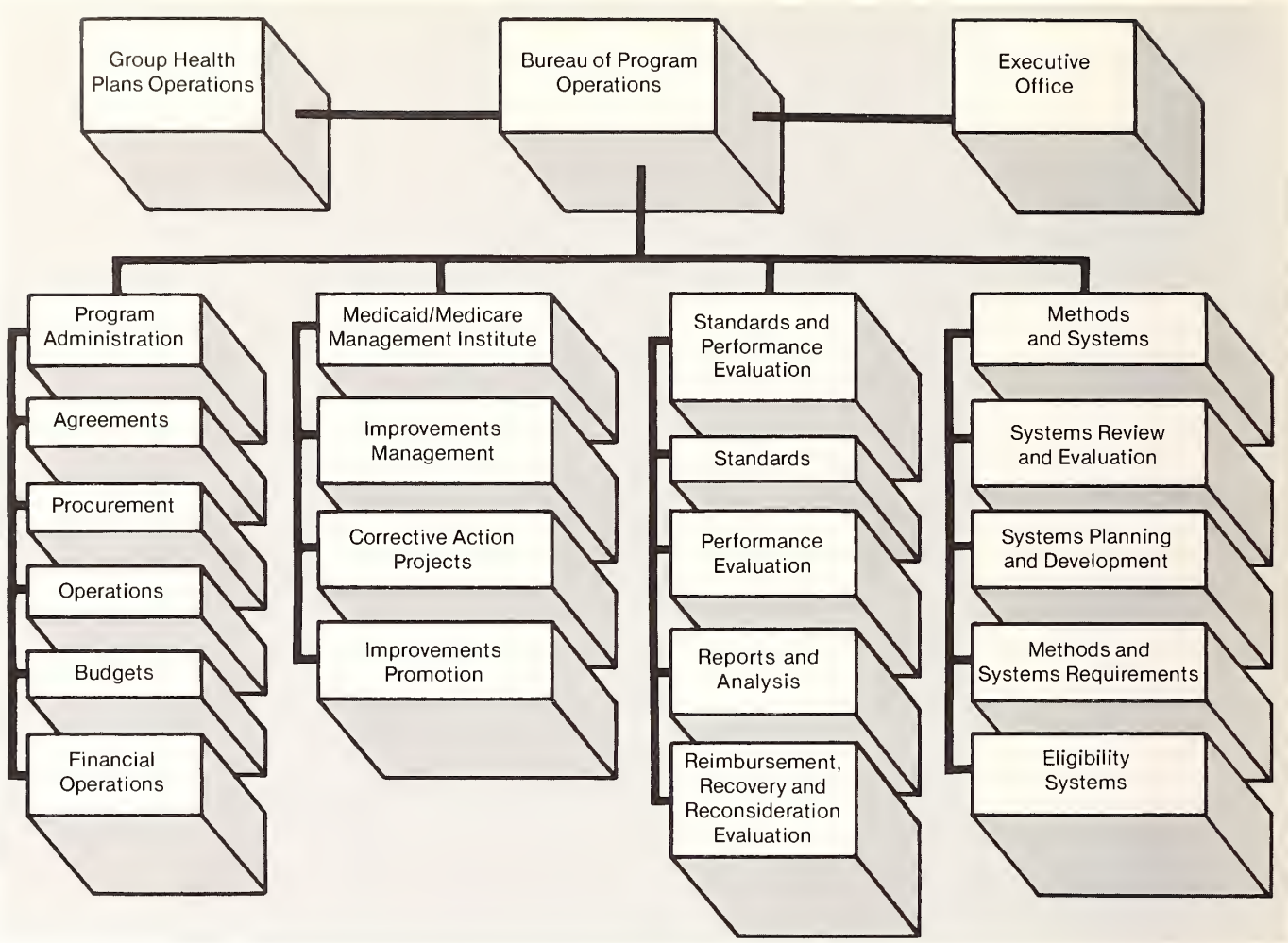
Methods and systems

The Office of Methods and Systems addresses the "how" issues of Medicare and Medicaid program operations. How does one enroll in the programs? How do health care providers get reimbursed? The office constantly seeks new and innovative ways to answer these questions and those which face contractors and state agencies in handling their enormous claims processing workloads.

In addition to establishing claims payment requirements, the Office of Methods and Systems sets criteria for contractors and state agencies in selecting a claims processing system, in subcontracting for claims processing services, for evaluating proposed systems, and for claims processing subcontracts.

Management institute

Improved program management is the basic objective of the Medicaid/Medicare Management Institute. The institute sponsors workshops and training programs for Medicare contractors and state Medicaid staffs, and conducts program training for staff of the Health Care Financing Administration.



The institute identifies high-priority management problems and serves as a catalyst and coordinator for corrective action initiatives. It provides advice and technical assistance to help states and contractors implement management improvements. Through the institute's clearinghouse and publications, information on program management techniques is disseminated to a wide audience. Two key publications are *Perspectives*, a periodic compilation of articles on program management, and the *Medicaid/Medicare Exchange*, which provides up-to-date notes on management developments among HCFA, the states, and contractors.

Staff offices

In addition to its four principal components, the Bureau of Program Operations has an executive office and a unit known as the Health Maintenance Organizations/Group Practice Prepayment Plans Staff. Both report directly to the bureau director.

The executive office handles the bureau's budget, personnel, and other administrative details. It also coordinates and monitors the bureau's fraud, abuse, and waste initiatives, the major initiatives tracking system, and work planning activities.

The Health Maintenance Organizations/Group Practice Prepayment Plans Staff works with other units of HCFA and HEW in planning and conducting a program to contract with HMOs and GPPPs to pay for services those organizations provide to Medicare beneficiaries. This unit also works with state agencies to promote state contracts with HMOs.

Integration initiatives

The HCFA reorganization sought to bring about a greater integration of the administrative processes of the Medicare and Medicaid programs. Although differences in the legal structure of the two programs preclude their total integration, similarities in the programs provide opportunities for achieving administrative economies and efficiencies.

Of considerable influence on the decision to consolidate Medicare and Medicaid was the prospect of a national health insurance program. With this integration accomplished, a major portion of developing and testing administrative mechanisms would already be accomplished should a national health insurance program be enacted.

Less than a year after HCFA's establishment in 1977, a task force on integration was formed to begin that job. When the agency reorganization was announced in March, 1979, substantial progress already had been achieved in some 20 integration projects.

Two integration projects of the bureau—a single claims form and a single audit—illustrate the benefits which the agency expects to derive from administrative consolidations. A single audit of hospitals, and eventually other institutions, will substantially lessen the time and money hospitals and other institutions now must devote in both preparing for the audits and in participating in them. Single audits are expected to eliminate the

Mildred Tyssowski, director of the Bureau of Program Operations, meets with bureau executives.

different, and sometimes inconsistent, interpretations auditors have reached using the same data.

Similar economies are expected to result from the use of a single claims form for Medicare and Medicaid. In addition, the use of a single Government form would likely have the added benefit of inducing health insurance organizations to adopt it for their use. A universal claims form for all health insurance claims would serve the best interests of all parties —patients, physicians, institutions, suppliers, and paying organizations.

The recent administrative consolidation is expected also to enhance the combined review of Medicaid and Medicare activities in states where the same fiscal agent serves both programs. The review of fiscal agents and contractors, who handle the bill payment processes, cover essentially the same areas—claims processing and payment, fiscal management and coverage, and utilization safeguards. Review of both programs by a single team would lessen the duplication which now occurs and would substantially reduce expenditures for preparing and participating in the reviews.

Although some states now use common fiscal agents for Medicare and Medicaid, their claims processing activities are often entirely separate. Increasing the number of common fiscal agents appears to be a reasonable short-term goal, and a totally integrated Medicare-Medicaid claims processing system appears to be desirable in the long run.

Because Medicare and Medicaid use private fiscal agents with whom the Federal Government or the states contract, the contracts themselves could be the vehicles for economies in administration. While many state Medicaid agencies have contracts with their fiscal agents for fixed rates of reimbursement, Medicare contractors are reimbursed for the costs of their operations, rather than at a fixed rate. This reimbursement method provides little incentive for a contractor to reduce costs or for introducing efficiencies that would eliminate waste and improve management.

Medicare has begun experimenting with competitive selection of contractors who would be paid a fixed price or would offer services at a fixed-rate. Under fixed-price contracts, intermediaries and carriers are reimbursed for performance—they get a net amount for doing the job. As a result, they are under greater internal management pressure to achieve greater efficiency and economy.

The first fixed-price contracts were negotiated with carriers handling payments to physicians. In Maine, this type of contract is expected to produce a savings of $1.1 million over its three-year term. A fixed-price contract in Illinois is expected to save $37.4 million during its four-year term, and one in the upstate New York area has a projected savings of almost $17 mililon for a three-year term.

Preliminary findings of these experiments indicate that a competitive fixed-price contract improves a contractor's performance and reduces the costs of operations. HCFA is now beginning to expand those experimental contracts to intermediaries who handle reimbursement for hospitals and other institutions, and the agency expects soon to begin solicitations for a combined carrier-intermediary fixed-price contract.

Both Medicare and Medicaid exist to serve people, and the ultimate measure of these programs is how well they serve. Consolidating operations can improve significantly the quality of service to beneficiaries of both programs. As employees of the new Bureau of Program Operations begin working closely, new opportunities for meshing the operations of Medicare and Medicaid are expected to occur, resulting in more efficiency and economy and, as a consequence, better service to the beneficiaries.

Martin Dyer has been director of the Bureau of Program Operation's Executive Secretariat.

HOSPITAL
COST REPORT
$67
258
312
45⁰⁰
127¹⁰
275⁰⁰

Bureau of Quality Control

by Bill Roskey

The Bureau of Quality Control works to eliminate errors, abuse, and waste in paying some $40 billion worth of health care bills annually for the nation's elderly, poor, and disabled.

"Although the methods the bureau uses to accomplish its mission can be sophisticated and complex at times, our basic mission can be stated simply," says Acting Bureau Director, John D. Kennedy. "It is to test the administration of HCFA programs to determine that payments are made only on behalf of eligible beneficiaries in the correct amounts for the services covered—but only for those services actually rendered and medically required."

To do this, the bureau develops and operates quality control and validation programs in concert with fiscal agents, state agencies, and regional offices.

Quality control most often is associated with manufacturing products, but its concepts and theories can be readily applied to procedures and systems such as claims processing, cost report settlement, and validation of beneficiary eligibility.

Bertrand Hanson's classic work, *Quality Control: Theory and Applications*, discusses quality as being important in three broad areas:

1. "*Quality of design* . . . of a product is concerned with the stringency of the specifications for the manufacture of the product. . . .

2. "*Quality of conformance to design* . . . is concerned with how well the manufactured product conforms to the original design requirements. . . .

3. "*Quality of performance* . . . is dependent upon both the quality of design and the quality of conformance. It can be the best design possible, but poor conformance control can cause poor performance. Conversely, the best conformance control in the world cannot make a product function properly if the design is not right. Thus, a continuing feedback system is necessary for providing quality information to act as a basis for decision-making regarding the optimizing of a quality product."

If the words "HCFA programs" are substituted for the word "product" in the above quotation, the bureau's job and how it fits into the overall HCFA responsibility can be readily understood.

The Bureau of Quality Control is composed of five major elements—the Office of Quality Control Programs, the Office of Program Validation, the Office of Financial Analysis, and the Office of Systems Analysis.

Quality control programs

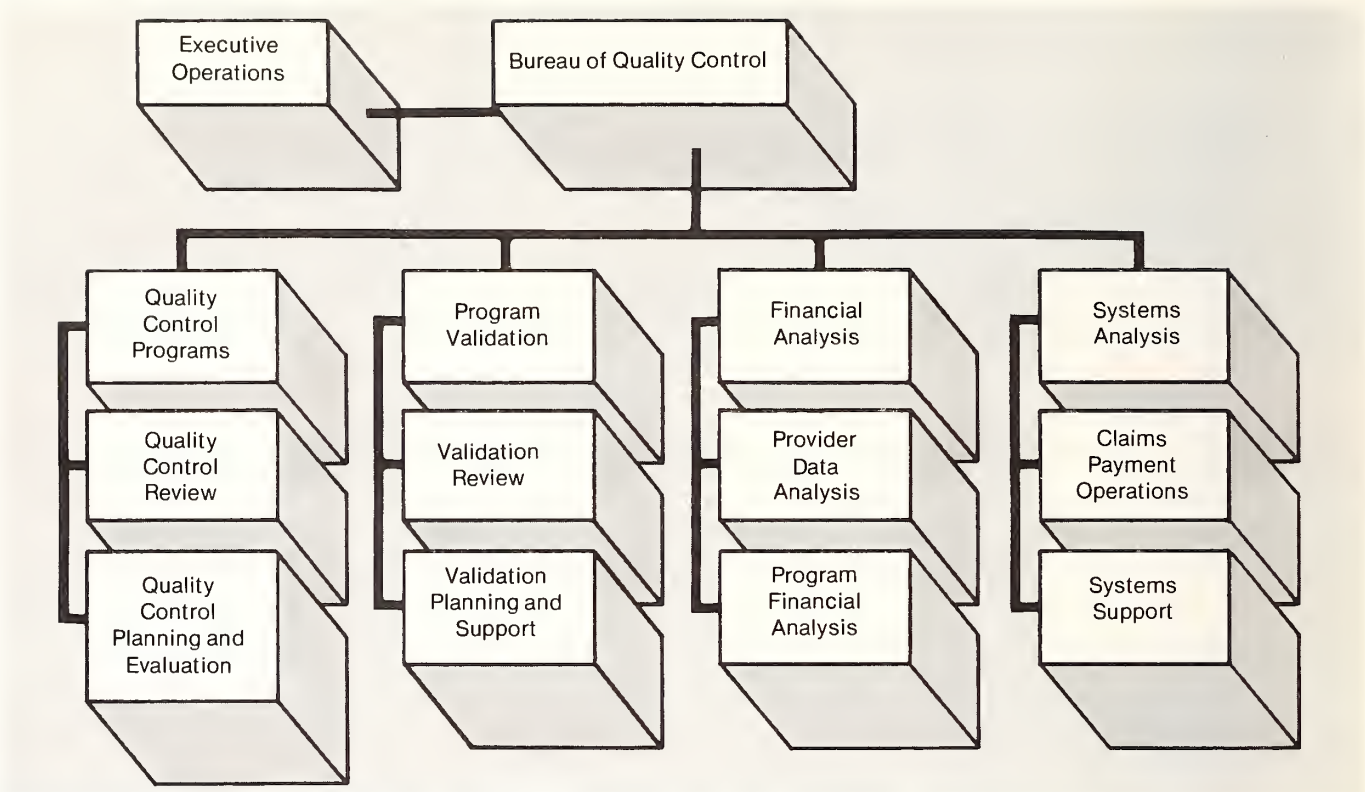
By sampling claims, bills, cases, cost reports, and survey reports, the Office of Quality Control Programs determines the effectiveness of quality control programs operated by carriers, intermediaries, and state agencies. It evaluates the results of quality control reviews and, where authorized by statute, makes recommendations for financial penalties or disallowances. Regional office personnel review samples and are largely responsible for direct interaction with contractors and state agencies. The regional offices forward their results to the Office of Quality Control Programs for analysis and for consolidation with reviews from all contractors and states.

Quality control programs currently are in operation for Medicaid covering eligibility, claims processing, third-party liability, and utilization of inpatient services. Quality control programs currently are operating in Medicare to evaluate the cost reports of hospitals and other institutions and to review claims from physicians and other health care professionals. The office also designs new quality control programs, sampling techniques, and survey instruments to improve or replace those now in use. Among the most important objectives of the office is incorporating the best techniques learned from the current programs into comprehensive methods of addressing all HCFA programs.

Evaluating bills (i.e., cost reports) from hospitals, nursing homes, and other institutions is somewhat more complicated than assessing bills (i.e., claims) from physicians. This is because physicians are paid a reasonable charge or a flat fee, while institutions are paid according to their cost of supplying services. Some hospitals allocate certain costs to their cost centers that Medicare or Medicaid do not cover. Some hospital services are used extensively by Medicare and Medicaid patients while others are little used.

HCFA investigations have shown that some hospitals have allocated disproportionally high overhead costs to the services used by Medicare and Medicaid patients, while lowering the overhead costs of services they do not use. In other cases, hospitals unintentionally may bill for treatment not covered, make an error in calculation, or fail to deduct their income from private patients before determining their final costs.

The analysis of how successful a contractor is in discovering billing irregularities and resolving them begins in the agency's 10 regional offices with a review of the payment practices of the contractors—fiscal intermediaries, carriers, related organizations—and state agencies. Regional offices continually monitor the con-



tractors' procedures by examining samples of claims they reject and samples that they approve for payment. If the contractor is found deficient, he is counseled on how the deficiency might be corrected and is required to report within a specified time what action is being taken to remedy the problem.

Program validation

The Office of Program Validation conducts onsite reviews for one or a combination of three reasons: (1) to determine if payments to individual providers may be indicative of potential fraud or abuse, (2) to systematically examine the effect of selected HCFA reimbursement policies and procedures, and (3) evaluate the effectiveness of state Medicaid agency and Medicare contractor processes for identifying and controlling fraud or abuse. "The centerpiece of our activity, as our name implies, is the conduct of validation reviews with staff or the central and regional offices," says Don Nicholson, director of the office. "These reviews take different forms depending on what we are looking for."

One form of review, the "program implementation review," is conducted by selecting an area where there is an indication that more Medicare or Medicaid dollars are being reimbursed than might be reasonable or prudent. Onsite reviews typically will be performed at state, Medicare contractor, or individual health provider locations, to determine under what conditions the payments are being made. Where findings resulting from these reviews are significant, recommendations for policy or operational changes are made. "This review is a form of internal audit," says Nicholson. "In conducting these reviews, we are trying to discover our own problems or deficiencies, so we can take the necessary action to clear them up."

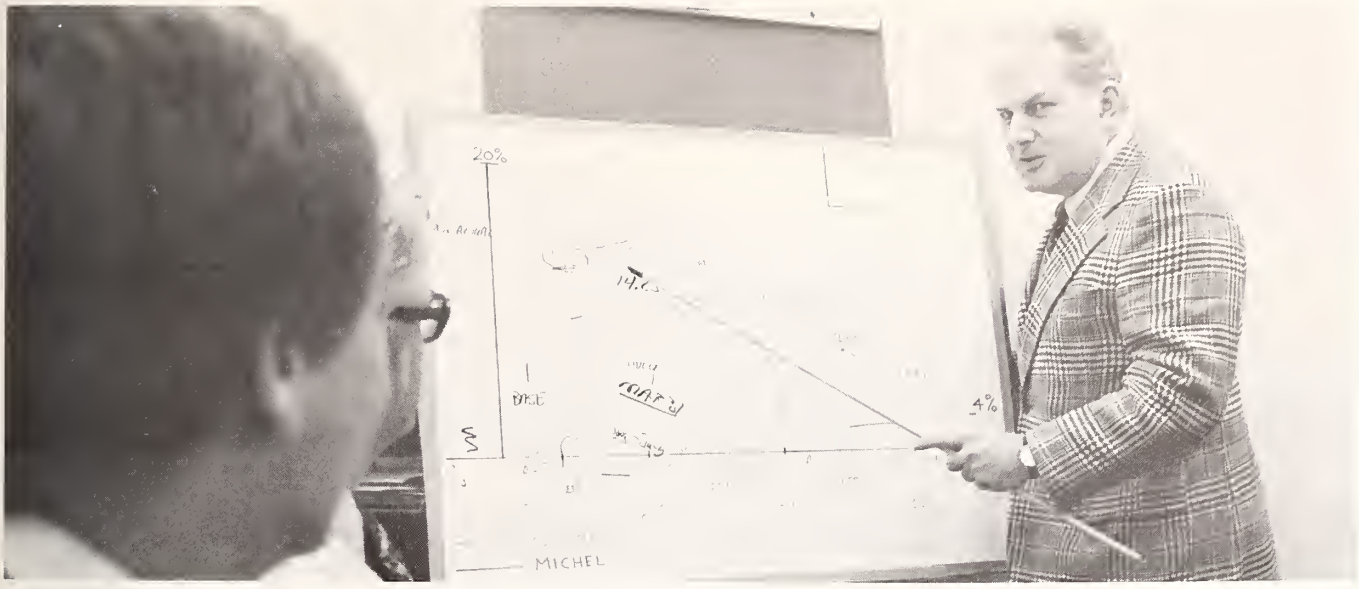
There are two other forms of program validation reviews which are called "aberrant cost studies" and "systematic fraud and abuse reviews." In conducting these reviews, program validation is attempting to discover and document reimbursement problems with specific health care providers. The aberrant cost studies represent reviews performed on health providers reimbursed on a cost basis, while the systematic fraud and abuse reviews are conducted on providers reimbursed on a charge or fee-related basis. Where a problem is noted, an overpayment is calculated, or other sanction or punitive action is taken.

Although conducting validation reviews constitutes the major portion of this office's responsibility, it is responsible for taking action on complaints about health providers received from beneficiaries or other sources. Reviews often are conducted with Medicare contractors or states, to determine if the complaint is valid.

If facts are discovered which indicate an attempt to defraud, referral is made to HEW's Office of Investigations, so that a criminal investigation can be conducted. During the first three quarters of 1979, some 216 referrals for criminal investigations have been made to the Office of Investigations.

When a case is successfully prosecuted, the health care provider is suspended from the program. The length of the suspension varies depending on the nature of the offense. Providers who have not been convicted of fraud, but who have engaged in practices which can be considered grossly abusive, also are expelled from the program. These latter actions rely greatly on recommendations received from Professional Standards Review Organizations. So far, the Office of Program Validation has taken suspension or termination action on 90 health care providers.

With limited resources, program validation staffs in the central and regional offices must depend heavily on states and contractors to contribute to the total effort. This contribution



John Kennedy, acting director of the Bureau of Quality Control, explains bureau goals.

is measured primarily through conducting validation reviews, and also by participating with other HCFA components in performing onsite inspection of contractors and state Medicaid agencies. Primary interest is focused on how the states and contractors are using prepayment and postpayment review systems to detect provider situations where fraud or abuse may exist. Workload reports also are collected from states and contractors which provide feedback from across the country regarding the level of effort.

The success of the Office of Program Validation is measured in terms of dollars identified for recovery, cases identified for referral for fraud investigation, and the identification of systemic policy or operational weaknesses that may be contributing to inappropriate expenditures.

Financial analysis

Where and how well HCFA spends the more than $40 billion a year in Medicare and Medicaid payments is determined by the Office of Financial Analysis.

The office maintains a schedule of costs and a statistical data base on 7,000 hospitals, 4,000 skilled nursing facilities, and 2,000 home health agencies. The costs of individual providers are compared with this data base to help determine if further examination of their cost reports is necessary. Cost reports from these providers are reviewed to identify those facilities which have (1) expense increases which exceed the President's inflation guidelines, (2) questionable practices in billing for reimbursement, or (3) costs that deviate from the norm.

The office generates summaries of data for Medicare contractors to use in comparing provider costs and for HCFA regional offices to use in evaluating contractors' payment processes. In addition, the office analyzes trends in costs and charges for services by geographic location, type of payer, or type of service, in order to identify deviations from norms. Studies are conducted on whether data reported to HCFA by providers are consistent with the data they report to other regulatory bodies such as the Internal Revenue Service and the Securities and Exchange Commission. One major initiative will be to extend these activities with Medicare providers to examine Medicaid costs and to combine data from all HCFA programs.

The office staff consists of economists, statisticians, accountants, and program analysts. They report on inflationary and deflationary trends in health care financing, trends of costs in the Medicare and Medicaid programs, differences in Medicare and Medicaid reimbursement, and differences in costs of delivering the same services through different methods. These analyses are expected to be major springboards of program improvement, by providing information on the effectiveness of the agency's standards.

Systems analysis

The expertise in using systems to discover patterns of practice that deviate from the norm and improper payments is in the Office of Systems Analysis. Computers are used to examine the data bases of Medicare and Medicaid contractors, which collectively contain more than 200 million transactions per year.

The office identifies providers and beneficiaries who have a high probability of eligibility errors, duplicate payments, third-party-liability errors, and other abuses. In addition, the office audits the computerized claims processing systems of the contractors to assure their fiscal integrity.

The Bureau of Quality Control addresses the integrity of HCFA payment systems as an integrated whole and uses new as well as established multi-discipline mechanisms and techniques.

Acting Bureau Director Kennedy summed up the importance of the bureau's efforts in a recent statement to his staff: "With the amount of dollars involved, our mission is at once a most ambitious undertaking and a limitless opportunity. If we are to improve the quality and integrity of HCFA services and payment processes, it will require our best efforts and the cooperation of all HCFA components, our fiscal agents, and the states."

Bill Roskey is a program analyst in the Bureau of Quality Control's Office of Systems Analysis.

Health Standards and Quality Bureau

by Veronica Oestreicher

A HCFA priority for Fiscal Year 1980 is to provide greater assurance that Medicare and Medicaid beneficiaries receive the most appropriate and highest quality health care services available. Another is to ensure that the delivery of these quality health care services is cost effective. Responsible for making these priorities realities is the Health Standards and Quality Bureau.

The bureau requires not only that facilities providing care to Medicare and Medicaid beneficiaries are structurally safe, provide for a sanitary environment, are well staffed, and have needed services available; but also that the actual care provided to the beneficiaries is of high quality. In addition the bureau is responsible for ensuring that medical services are necessary and are provided in the most appropriate setting. These efforts assure high quality of care for beneficiaries while at the same time reduce health care costs.

Within the bureau, the two primary organizations that carry out its mission are the Office of Standards and Certification and the Office of Professional Standards Review Organizations.

Standards and certification

By law, any facility providing health care to Medicare and Medicaid beneficiaries must meet certain health and safety standards before it can be eligible to receive reimbursement from the two programs. Federal safety and health standards range in character from structural requirements such as room size and the supply of hot water that must be available to quality care assurances such as requiring adequate staffing with appropriately trained personnel. The Office of Standards and Certification develops and enforces these standards.

In order to ensure that the standards are met, the law provides for an annual survey of each facility. These surveys are conducted by each of the states under a contract with HEW. If, as a result of the survey, a facility fails to meet Federal standards, it is not certified. This means that no Federal money can be paid to it for patient care under either the Medicare or Medicaid programs. This does not mean that a facility must close, or that it will lose its license to operate. The licensing of a facility is the responsibility of each individual state and is subject to its own requirements.

HCFA's regional offices monitor standards enforcement and the states' survey and certification of health care facilities. However, the procedures for these two activities are established by the Office of Standards and Certification. To carry out its work, this office has five divisions—Division of Hospital Services, Division of Long-Term Care, Division of Laboratory and Ambulatory Services, Division of Program Analysis and Training, and the Division of Field Operations.

The Division of Hospital Services prepares and analyzes the quality and safety standards for hospitals and end-stage renal disease facilities. Under the Medicare law, hospitals that meet the privately-run Joint Commission on Accreditation's health and safety standards are considered to have met the Federal Government's requirements. However, the 1972 Social Security Amendments directed HEW to conduct surveys in the commission's accredited hospitals on a sample basis in order to validate that the commission's surveys continue to meet Medicare requirements. The Division of Hospital Services is therefore also responsible for arranging these validation surveys by the state survey agencies.

The Division of Long-Term Care develops and analyzes standards for skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded.

The Division of Laboratory and Ambulatory Services establishes standards and analyzes them for clinical and other laboratories, ambulatory care facilities, rural health clinics, outpatient physical therapy and speech pathology, independent physical therapists, and home health agencies.

The Division of Program Analysis and Training provides training programs in certification and survey procedures for regional offices and state agencies. Based on information and needs identified by other divisions of the Office of Standards and Certification, this division develops new and more effective approaches to setting standards and to survey and certification procedures.

The Division of Field Operations develops administrative and fiscal policies for state survey agencies. Other activities include survey and certification data analyses and preparation of procedures used by regional offices to monitor state survey agencies' operations.

PSROs

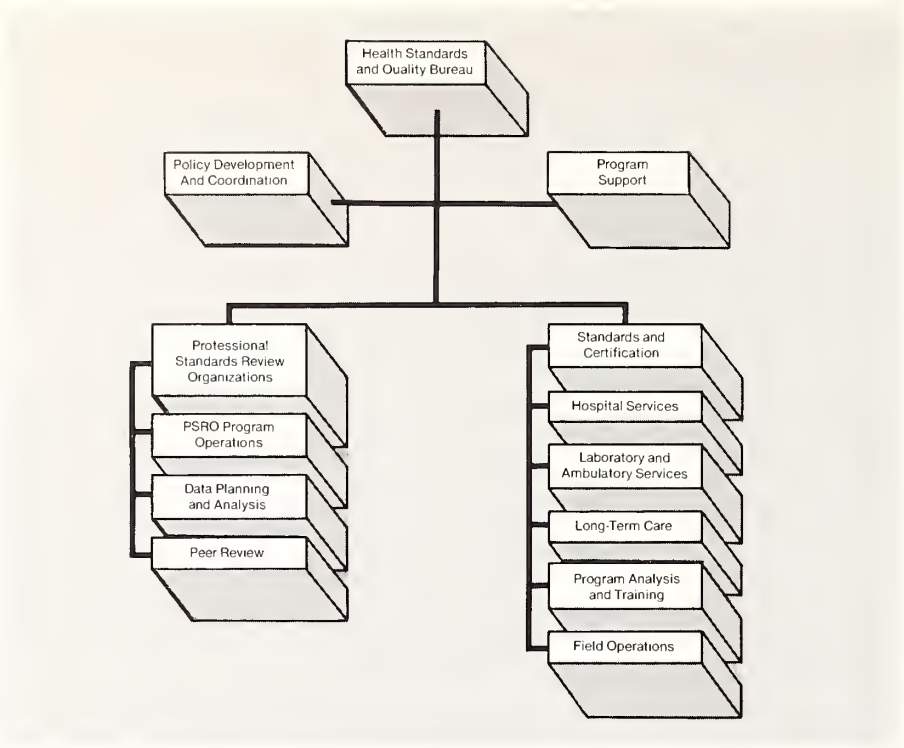
The nationwide program by which groups of physicians review the work of their colleagues to ensure high quality care, while minimizing unnecessary costs, is directed by the Office of Professional Standards Review Organizations.

About 140,000 physicians in about 190 areas throughout the country have formed review groups, known as PSROs, to assure that health care services for Medicare and Medicaid patients are of a quality that meets professionally recognized standards of care, are medically necessary, and are appropriately provided in the most economical settings. PSROs are organized and administered by physicians and receive financial support from the Health Standards and Quality Bureau.

PSROs are required to review health care provided in hospitals and long-term-care facilities which have been certified as meeting federal standards. Eventually, they may expand their review system to cover ambulatory care. At present, however, review of hospitalized patients is by far the most important responsibility of PSROs.

PSRO review consists of examining criteria for admission and length of stay approval, auditing the quality of care, and analyzing the practice profiles of physicians and institutions. Locally professionally determined criteria for acceptable medical practice serve as the basis for reviews.

PSROs hospital review of an ad-



mission normally begins with an examination of the patient's admission records to determine whether hospitalization was necessary. If the admission is judged necessary, a notation is made of the expected length of stay, using regional or local norms. Payments end on the projected day of discharge, unless an extension is approved. An example of an unnecessary admission is when a patient is treated as a hospital inpatient for a diagnostic procedure that could be performed at a physician's office or at a hospital on an outpatient basis.

Persons reviewing admission records, known as review coordinators, are usually nurses who have been trained in PSRO review procedures. When a reviewer finds a questionable admission or length of stay, it is brought to the attention of a PSRO physician, who determines whether it is justified. The patient's attending physician is given an opportunity to explain the situation, but if the admission or extended stay cannot be justified, Federal payment is denied.

Quality of care audits are perhaps the PSROs most important quality assurance mechanism. For instance, an audit of quality of care may reveal that some physicians still prescribe drugs proven to be ineffective in treating certain conditions. In such cases, the PSRO would make sure that these physicians are informed about the drugs and the procedure currently being used for treatment.

Practice profiles are used to pinpoint undesirable deviations from the norm. For instance, a comparison of hospital infection rates for a surgical procedure may show that one hospital has an especially high rate of infection. In such a case, a quality care audit might be performed to determine the cause and how the infection rate might be lowered.

The Office of Professional Standards Review Organizations develops the review, quality assurance, organizational, and fiscal management policies of PSROs. In addition, it collects and analyzes data, develops performance standards, and assesses the performance of each PSRO. The HCFA regional offices are responsible for providing assessments to PSROs in implementing Federal policies and for monitoring and reviewing individual PSRO performances. The Office of Professional Standards Review Organizations has three divisions to do its work—Division of Peer Review, Division of Data Planning and Analysis, and Division of Program Operations.

The Division of Peer Review designs and interprets all policies, procedures, and methods for the medical assurance and review programs. It also develops guidelines for physicians and other health care practitioners to carry out reviews.

The Division of Data Planning and Analysis develops data systems, policies, procedures, and requirements. For the effective management and evaluation of PSRO activities, this division designs and implements a management information system, a statistical reporting system, and other reporting systems. It also tests approaches and develops policies and technical assistance materials to aid PSROs in their profile analyses.

The Division of Program Operations provides the overall programmatic and technical management of the bureau's grants and contracts to PSROs and arranges for any technical assistance to them. To document the effectiveness and impact of each PSRO and to determine their compliance with program requirements, the division administers a comprehensive assessment system.

Increasing effectiveness

HCFA's current organizational structure is designed to improve management and performance in order to accomplish its priorities in such areas as quality assurance, cost control, reduction of fraud and abuse, improved management control, program simplification, and improved responsiveness to beneficiaries and the public. The Health Standards and Quality Bureau has begun to undertake some major initiatives to contribute to the successful achievement of these priorities.

The bureau's Office of Standards and Certification is developing new standards, or "Conditions of Participation," for hospitals and nursing homes. The general thrust of the proposed hospital standards is to give hospitals increased flexibility in using their resources, while maintaining an acceptable level of health care and safety. The objective of the proposal is to build flexibility into the standards because the present, rather detailed, and complex standards are considered excessively burdensome and ineffective for some hospitals, especially smaller ones.

For example, present standards require every hospital to have 14 committees or groups (e.g., medical records committee, infection control committee) that meet a specific number of times. One very small hospital, wrote the bureau to say that the two physicians on its staff had difficulty figuring out which committee meeting

they were attending at coffee break and which at lunch. They found that they were required to keep minutes of almost every conversation they had with one another, if they were to meet the requirements for records of committee meetings. The proposed standards require that the functions accomplished by committees continue to be carried out, but the mechanism for doing so be optional.

The proposed regulation regarding nursing home standards also has been made less complex. In addition, these standards will more accurately measure the quality of care provided patients. Current regulations have been criticized for focusing on the process of care rather than the result of care, thereby contributing to the cost of care without necessarily improving it. It is alleged that while the standards may ensure that a facility—its policies, staffing, and structure—is capable of providing quality care, they do not measure the care delivered to each individual patient.

For example, although it is required that a registered nurse be on duty in a skilled nursing facility during the day, the surveyors are not required to see how the registered nurse's presence is affecting the care received by the patients.

The proposed changes address this concern by requiring that each facility have a "patient care management system," to measure the care delivered. This would require an interdisciplinary team to assess each patient's needs, develop a plan of care, write a periodic evaluation of the patient's condition, assure that the desired results are being accomplished, and develop a formal plan for discharge. The exact form of this system could be chosen by each institution. The proposed changes would also address patients' rights by providing for input in the survey process from patients and their families on the quality of life in a facility.

A third initiative by the Office of Standards and Certification is the implementation of the new Fire Safety Evaluation System for Health Care Facilities. This system is the result of the National Bureau of Standards' investigation into alternate methods of assessing protection from fire in health care facilities. The investigation was made because the fire safety code required hospitals and other health care institutions to undertake large capital expenditures in order to correct their fire safety code deficiencies.

Dr. Smits (center), director of the Health Standards and Quality Bureau, confers with aides.

It has been argued that these expenses are frequently not warranted to ensure patient safety. The use of the new system will reduce or eliminate unnecessary expenses by determining how various combinations of requirements may provide an equivalent level of safety from fire to that obtained by strict compliance with the code.

The major initiatives of the Office of Professional Standards Review Organizations are aimed at continuing to improve the impact of PSROs. They include setting performance objectives, reducing costs, and consolidating PSRO areas. The performance objectives are necessary because, with a limited annual budget, PSROs must concentrate their reviews on the most pressing problems. Each PSRO's objectives are established locally and must be founded on data provided through regional and national statistics.

The objectives must be as specific and as tough as possible and include a measurable estimate of impact, in terms of utilization, or quality, or both. For example, one objective might be a two-day reduction in the length of stay in hospitals for cataract surgery, if the regional average is four days, but the PSRO's average is six. In the future, PSROs also will be asked to meet specific national goals in order to remedy the nation's top priority problems as well as their local problems.

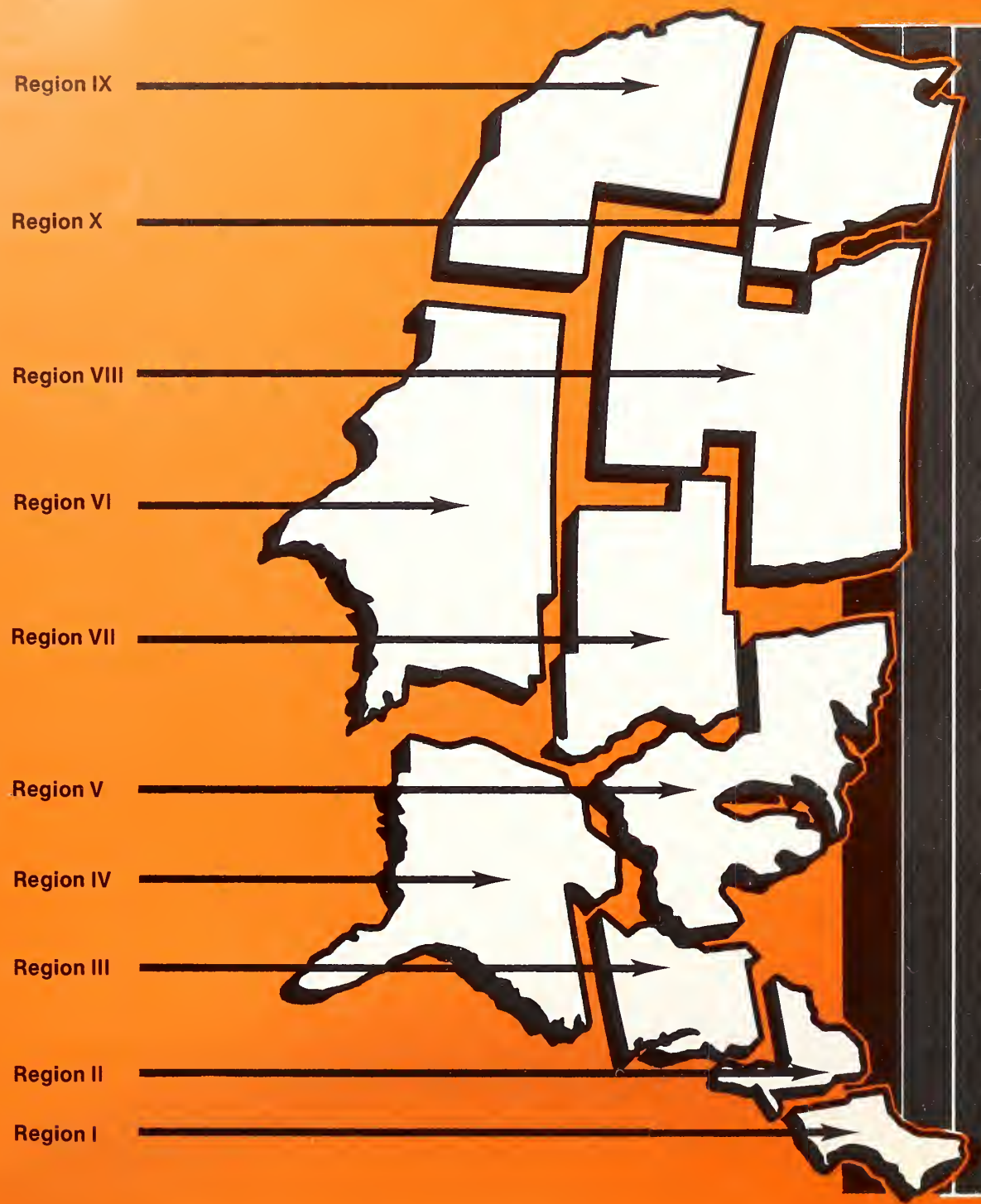
Reducing the unit cost of review is another area of emphasis for improving program efficiency. The major cost reduction effort is focused review. Focusing review means decreasing PSRO review activity in areas of consistently acceptable performance and concentrating review on significant problem areas. Detailed review performed on 100 percent of Medicare and Medicaid admissions is no longer necessary, now that data systems are in place that can be relied on to point out problem areas.

Finally, the PSRO program is working on the consolidation of small PSROs. The uniformity of overhead costs between small and large PSRO areas, the budget limitations, and the PSRO need to depend on area-wide data systems lead to a clear conclusion: Some PSROs are too small. The bureau has and will be supporting and encouraging consolidation, particularly in Maryland and California. Such consolidation will either be total or through the sharing of data base and data analyses.

The Health Standards and Quality Bureau is unique within the Health Care Financing Administration in its orientation toward quality assurance and cost control through review mechanisms. This role, along with initiatives of the Administration's other priority areas, well links the bureau into the new reorganization.

"The bureau, which was formed out of elements from the Public Health Service and from the old Medicare Bureau, is like a miniature HCFA," says Dr. Helen Smits, director of the Health Standards and Quality Bureau. "By bringing together all quality assurance activities in one place and fully integrating them, we will be able to make close connections between related elements such as the PSRO Long-Term-Care Projects and the Office of Standard and Certification's Division of Long-Term Care. We have an exciting time ahead of us."

Veronica Oestreicher is a health policy analyst in the Health Standards and Quality Bureau Director's Office.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Regional Offices

While strategy for achieving HCFA objectives is developed for the most part in Washington, how well these objectives are carried out depends in large part on the 1,850 employees in the agency's 10 regional offices. These staffs direct the activities of HCFA's contractors and state agencies employing more than 20 times their number.

The function of HCFA's regional offices is directly related to two major goals of the agency:

- Developing comprehensive agreements with contractors and states that stipulate the conditions under which HCFA programs are carried out, the performance standards that must be met, and the programmatic results that are to be achieved.
- Monitoring the performance of contractors and states in administering HCFA programs to assure it is consistent with program and performance standards, and directly monitoring health care providers to assure that programmatic goals are achieved.

The regional staffs develop comprehensive agreements with the contractors and state agencies that operate the bill processing systems and the health care evaluation system for the agency. These agreements stipulate the conditions under which programs are carried out, the standards that must be met, and the results that are expected.

In establishing an agreement with a Professional Standards Review Organization, for example, the regional staff negotiates the type of operating structure of the PSRO, its budget, and its goals. Should contractors or state agencies encounter problems in achieving standards, regional office personnel provide advice and technical assistance.

Monitoring the performance of contractors and state agencies to insure that standards are met and goals are reached within the prescribed time, is another responsibility of the regional offices. Monitoring Medicare contractors, for instance, calls for a number of assessments, including on-site audits of performance.

The regional offices also coordinate investigations of fraud and abusive practices by health care professionals and institutions.

Located in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City (Missouri), Denver, San Francisco, and Seattle, the regional offices are in daily contact with HCFA's agents who are responsible for program administration, and with providers of services. They audit activity to assure appropriate fiscal administration of HCFA programs; assess activity to assure appropriate service delivery to HCFA beneficiaries; and lend technical assistance to contractors, state agencies, and providers to remedy problems and ensure consistent, effective program operation.

Although regional personnel are responsible primarily for assuring that objectives are achieved, they influence the setting of HCFA policy by reporting to the headquarter's office on the practical aspects of implementing suggested policies.

The regional offices are both a sounding board for the reasonableness of policy and a principal source of ideas for improvements.

Regional offices can be contacted as follows:

- Region I—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont—Tera Younger, acting regional administrator, John F. Kennedy Federal Building, Room 1309, Boston, Massachusetts 02203 (617-223-6871).
- Region II—New York, New Jersey, Puerto Rico, Virgin Islands—William Toby, regional administrator, 26 Federal Plaza, Room 3811, New York, New York 10007 (212-264-4488).
- Region III—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia—Everett Bryant, regional administrator, 3535 Market Street, Room 3100, Philadelphia, Pennsylvania, 19101 (215-596-1351).
- Region IV—Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee— Virginia Smyth, regional administrator, 101 Marietta Street, Suite 701, Atlanta, Georgia 30323 (404-242-2329).
- Region V—Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin—George Holland, regional administrator, 175 West Jackson Boulevard, Room A835, Chicago, Illinois 60604 (312-353-8057).
- Region VI—Arkansas, Louisiana, New Mexico, Oklahoma, Texas —J. D. Sconce, regional administrator, 1200 Main Tower Building, Room 2400, Dallas, Texas 75202 (214-729-6427).
- Region VII—Iowa, Kansas, Missouri, Nebraska—Gene Hyde, regional administrator, 601 East 12th Street, Room 564, Kansas City, Missouri 64106 (816-758-5233).
- Region VIII—Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming—Francis Ishida, regional administrator, Federal Building, 1961 Stout Street, Room 628, Denver, Colorado 80294 (303-837-2111).
- Region IX—American Samoa, Arizona, California, Guam, Hawaii, Nevada—Philip Nathanson, regional administrator, 100 Van Ness Avenue, 14th Floor, San Francisco, California 94102 (415-556-0254).
- Region X—Alaska, Idaho, Oregon, Washington—Joseph Anderson, regional administrator, Arcade Plaza Building, 1321 2nd Avenue, Room 8618, Mail Stop 804, Seattle, Washington 98101 (206-399-0425).

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prepares statements and briefing materials for appearances by the Administrator and other HEW officials before congressional committees, coordinates legislative planning within the agency and HEW, and is the agency's liaison with members of Congress and their staffs.

The Office of Policy Analysis reviews HCFA's program policy and studies new policy initiatives. The staff reviews all current regulations, proposed regulations, and proposed and pending legislation pertaining to health care financing programs. The policy implications are carefully studied, and these studies provide information on which to base the agency's legislative program and long-range planning activities. Studies may concern such areas as reimbursement of physicians, laboratories, and Health Maintenance Organizations; Medicaid eligibility reform; reforms in Medicare benefits or Federal involvement in the sale of Medicare supplementary insurance coverage.

Office of Management and Budget

The principal tasks of the Office of Management and Budget are to assure the agency has the necessary budget, personnel, skills, physical plant, supplies and management process to achieve its mission.

The office hires, classifies, and assigns about 4,600 full-time employees and provides for their training. In addition to managing the agency's human resources, the office writes and approves contracts for goods and services for all components of the agency and assures that grants awarded by HCFA are in conformance with all Federal policies.

When the decision was made to move HCFA's 2,000 headquarters employees from Washington to suburban Baltimore earlier this year, the office selected the new office space and contracted for moving the agency's furniture, equipment, and supplies to the new location. It also devised a plan to reimburse employees who wanted to change their residence to the Baltimore area.

Providing the Administrator with the information necessary to set goals for the agency and monitoring progress toward those goals is a major ongoing task. A top priority of the office is to complete an internal management control system which will provide a better method for establishing accountability, tracking progress, and integrating the schedules of HCFA units involved in regulations, operations, legislative proposals, and budget. An important part of this system measures the performance of senior level managers in order to determine which ones should receive merit pay and other rewards.

The office is also working to identify opportunities to enhance the agency's data management system, by analyzing consolidated data collection and processing alternatives. Currently, nearly all units of the agency have separate data collection and processing systems which overlap considerably in many areas. Not only will a single cohesive system be more efficient, but also it will allow comparisons of information from various sources. These comparisons are expected to yield valuable insights to methods of reducing costs in financing HCFA programs.

HCFA Headquarters–Woodlawn, Md.

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Directory of HCFA Offices

Office of the Administrator

Room 5000 MES Building
Washington, D.C. 20201

Leonard D. Schaeffer, Administrator
Tel. 202 245-6726

Earl M. Collier, Jr., Deputy Administrator
Tel. 301 594-7914

Equal Opportunity Office
George James, Director
Tel. 301 594-7761

Office of Health Regulation
John Reiss, Director
Tel. 202 245-1686

Office of Intergovernmental Affairs
Richard Heim, Director
Tel. 301 594-9725

Office of Professional and Scientific Affairs
Roger Egeberg, Director
Tel. 202 245-0577

Office of Special Programs
Tel. 202 245-1724

Office of Beneficiary Services
Barney Sellers, Director
Tel. 301 594-8131

Office of Executive Operations

Room 5110 MES Building
Washington, D.C. 20201

Kevin J. Sexton, Director
Tel. 202 245-1724

Office of Public Affairs

Room 5221 MES Building
Washington, D.C. 20201

Patricia Q. Schoeni, Director
Tel. 202 245-0381

Office of Management and Budget

Room 5000 MES Building
Washington D.C. 20201

Howard Phanstiel, Director
Tel. 202 245-0835

Office of Research, Demonstrations and Statistics

5054 MES Building
Washington, D.C. 20201

James Kaple, Acting Director
Tel. 202 245-2184

Office of Legislation and Policy

Room 5074 MES Building
Washington, D.C. 20201

Jeff Merrill, Director
Tel. 202 245-0301

Bureau of Support Services

3-F-3 Meadows East Building
Baltimore, MD 21235

Ralph Howard, Director
Tel. 301 594-7643

Office of Direct Reimbursement
Tel. 301 594-8018

Division of Beneficiary and Provider Systems
Tel. 301 594-2558

Bureau of Program Operations

300 East High Rise Building
Baltimore, MD 21235

Mildred Tyssowski, Director
Tel. 301 594-7410

Group Health Plan Operations Staff
Tel. 301 594-7997

Program Administration
Tel. 301 594-9470

Standards and Performance Evaluation
Tel. 301 594-8431

Methods and Systems
Tel. 301 594-9545

Medicaid/Medicare Management Institute
Tel. 301 594-8646

Bureau of Program Policy

100 East High Rise Building
Baltimore, MD 21235

Robert O'Connor, Director
Tel. 301 594-9324

Office of Coverage Policy
Tel. 301 594-9690

Office of Eligibility Policy
Tel. 301 594-9682

Office of Reimbursement Policy
Tel. 301 594-9760

Bureau of Quality Control

2-E-5 East Low Rise Building
Baltimore, MD 21235

John Kennedy, Director
Tel. 301 594-5840

Office of Quality Control Programs
Tel. 301 597-1340

Office of Program Validation
Tel. 301 594-8470

Office of Financial Analysis
Tel. 301 594-5878

Office of Systems Analysis
Tel. 301 597-1898

Health Standards and Quality Bureau

5046 MES Building
Washington, D.C. 20201

Helen W. Smits, Director
Tel. 202 245-0284

Office of Professional Standards Review Organizations
Tel. 301 594-9207

Office of Standards and Certification
Tel. 301 597-2750

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